

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11335

11390

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#2				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ball Road				e. STREET ADDRESS Ball Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BESSIE Middle LAVINA Last ADAMS				4. DATE OF DEATH Month October 24, Day 19 Year 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1903	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.		IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Thorpe				14. MOTHER'S MAIDEN NAME Hester Conklin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-20-8253		INFORMANT Mr. George L. Danner 311 East Main Street, Emmitsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Acc. Curled 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) C.H. Cardiovascular Disease DUE TO (c) 2 3/4						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-2 , 19 59 to 10-24 , 19 59 , that I last saw the deceased alive on 10-24 , 19 59 , and that death occurred at 7:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) West All Saints Street DATE SIGNED 10/26/59							
ACTUAL SIGNATURE M. J. Bourne Jr.		M.D. West All Saints Street					
PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D.		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 27, 1959		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cascade, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT. 27 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

On or about ...

at ...

the ...

year ...

deceased ...

John ...

born ...

of the ...

County of ...

State of ...

City of ...

County of ...

State of ...

City of ...

County of ...

State of ...

City of ...

County of ...

State of ...

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11336

11393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/ d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nina Middle H. Last Ahalt				4. DATE OF DEATH Month 10 Day 18 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/25/1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oliver Hightman				14. MOTHER'S MAIDEN NAME Helen A. Hixon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		INFORMANT Address Charles E. Ahalt, Burkittsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) advanced Arterio-Sclerosis DUE TO (c) (Has had two previous Hemorrhages) INTERVAL BETWEEN ONSET AND DEATH 5 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 18, 1959 to Oct 18, 1959 that I last saw the deceased alive on Oct 18, 1959 , and that death occurred at 10:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middleton 10-19-59 DATE SIGNED ACTUAL SIGNATURE J Elmer Harp M.D. Middleton PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp Middletown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/21/1959		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR OCT 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11337

11353

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>THURNIEN</u> Last <u>ANDERS</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 7 - 1871</u>	
9. AGE (In years last birthday) yrs <u>88</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WILLIAM H ANDERS</u>				14. MOTHER'S MAIDEN NAME <u>CLARISSA CREAGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ALICE STITELY</u> Address <u>UNION BRIDGE RURAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Left Breast</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>second-gum</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July</u> , 1957, to <u>Oct 12</u> , 1959, that I last saw the deceased alive on <u>Oct. 12</u> , 1959, and that death occurred at <u>6:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Waldenville, Maryland</u> DATE SIGNED <u>Oct. 13/59</u>							
ACTUAL SIGNATURE <u>Ernest A. Dettbarn</u> M.D.				PHYSICIAN'S NAME (Type) <u>ERNEST A. DETTBARN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 15-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>		22d. LOCATION (City, town, or county) (State) <u>WOODSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D D Hartgering & Sons Union Bridge Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11338

11354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1317 North Market Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last BARRICK				4. DATE OF DEATH Month October Day 2 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 9, 1870	
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles W. Barrick				14. MOTHER'S MAIDEN NAME Arianna Norris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Miss Hattie M. Buckey—Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 to 10/2 , 1959, that I last saw the deceased alive on August 12, 1959 , and that death occurred at 7:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building Frederick, Maryland DATE SIGNED 10/3/59							
ACTUAL SIGNATURE James B. Thomas		M.D. Professional Building Frederick, Maryland					
PHYSICIAN'S NAME (Type) James B. Thomas, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 6 '59	
				24b. REGISTRAR'S SIGNATURE Etchison & Son			

1999

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11394

CERTIFICATE OF DEATH

Reg. Dist. No.

11340

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown				c. LENGTH OF STAY IN 1b 7 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley View Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Minnie F. Beachley				4. DATE OF DEATH 10 11 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/26/1901	
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min. 58		11. IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min. 58		12. IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Frank Beachley				14. MOTHER'S MAIDEN NAME Cora Nash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none			
17. INFORMANT Charles Beachley, Middletown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Pneumonia Edema Myocardial DUE TO Coronary Disease Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Disease Failure (c) Coronary Disease Failure				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 19 59 to May 19 59 that I last saw the deceased alive on May 19 59 and that death occurred at 412 M , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Jefferson, Md.			
ACTUAL SIGNATURE Dr. A. Talbott Brice M.D.				DATE SIGNED 10/12/59			
PHYSICIAN'S NAME (Type) Dr. A. Talbott Brice				Jefferson, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 10/14/1959			
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery				22d. LOCATION (City, town, or county) (State) Middletown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				ADDRESS			
24a. REC'D BY REGISTRAR OCT 15 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11341

11395

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg c. LENGTH OF STAY IN 1b 30 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) East Main Street				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg d. STREET ADDRESS East Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Harry Middle T Last Bollinger				4. DATE OF DEATH Month October Day 9 Year 19 59													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1905		9. AGE (In years last birthday) 54 yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Butcher		11. BIRTHPLACE (State or foreign country) Adams Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME John Bollinger				14. MOTHER'S MAIDEN NAME Mary Catherine Sterner													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Roy Valentine</i> Address <i>Shawmut Md</i>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cerebral Hemorrhage</i> DUE TO <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular disease</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>B. O. Thomas</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED									
EXAMINER'S NAME (Type) B. O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 10, 1959									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.											
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Wilson</i>						ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur G. Kraus</i>							

C. E. Wilson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John William		SEX Male		AGE 30 years	
DATE OF DEATH October 10, 1920		PLACE OF DEATH Home		CITY Baltimore	
MANNER OF DEATH Natural		CAUSE OF DEATH Pneumonia		DISEASE OR INJURY Pneumonia	
DATE OF BIRTH October 10, 1890		PLACE OF BIRTH Maryland		CITY Baltimore	
MANNER OF BIRTH Natural		CAUSE OF BIRTH Pneumonia		DISEASE OR INJURY Pneumonia	
DATE OF DEATH October 10, 1920		PLACE OF DEATH Home		CITY Baltimore	
MANNER OF DEATH Natural		CAUSE OF DEATH Pneumonia		DISEASE OR INJURY Pneumonia	
DATE OF BIRTH October 10, 1890		PLACE OF BIRTH Maryland		CITY Baltimore	
MANNER OF BIRTH Natural		CAUSE OF BIRTH Pneumonia		DISEASE OR INJURY Pneumonia	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8. See: Birth Cert. et

CERTIFICATE OF DEATH

11339

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>44 CARVER APTS.</u>	
3. NAME OF DECEASED (Type or print) <u>Austin</u> First <u>Thomas</u> Middle <u>Bowie</u> Last		4. DATE OF DEATH <u>October 12</u> Month <u>1959</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/08/1901</u> 9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Austin N. Bowie</u>		14. MOTHER'S MAIDEN NAME <u>Esther L. Summers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Esther Bowie</u> Address <u>44 CARVER APTS.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis of newborn</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>26 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/08/1901</u> , 19 <u>55</u> , to <u>11/12/1959</u> , that I last saw the deceased alive on <u>11/12/59</u> , 19 <u>59</u> , and that death occurred at <u>1:15 PM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10/12/59</u>			
ACTUAL SIGNATURE <u>A. M. Powell Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>A. M. POWELL JR.</u>		<u>TOLL HOUSE AVENUE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BARTONSVILLE</u>	22d. LOCATION (City, town, or county) (State) <u>Fred. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u> ADDRESS <u>Fred. Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

2169192XU1

MAKYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11342

11356

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Knoxville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>JONATHAN EMMETT BROWN</u>		4. DATE OF DEATH <u>October 28 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 27, 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>23</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>23 34</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick J. Brown Jr.</u>		14. MOTHER'S MAIDEN NAME <u>JEAN O. HASTINGS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MOTHER</u>		Address <u>KNOXVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>27 Oct</u> , 19 <u>59</u> , to <u>28 Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>27 Oct</u> , 19 <u>59</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Fred J. Heldrich Jr.</u> M.D. <u>MEDICAL CENTER</u> PHYSICIAN'S NAME (Type) <u>FRED J. HELDRICH JR.</u> <u>FREDERICK MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-29-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>	22d. LOCATION (City, town, or county) (State) <u>Brunswick MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. L. Felt</u> ADDRESS <u>Brunswick, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>

2069332XU2

11396

CERTIFICATE OF DEATH

Reg. Dist. No.

11343

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville		c. LENGTH OF STAY IN lb 88 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1				d. STREET ADDRESS Route # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle FRANKLIN Last CARTEE				4. DATE OF DEATH Month October Day 10 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December, 19, 1870		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Gen. Farm		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frisby Cartee				14. MOTHER'S MAIDEN NAME Louisa Grossnickle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Grayson F. Cartee, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic cardiovascular disease 10 yrs. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-25-57 , 19__, to 10-10-59 , 19__, that I last saw the deceased alive on 10-5-59 , 19__, and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 10-10-59 ACTUAL SIGNATURE Charles F. Hess M.D. PHYSICIAN'S NAME (Type) Charles F. Hess Smithsburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Grossnickle's		22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle ADDRESS Myersville, Md.				24a. REC'D BY REGISTRAR OCT 13 1959 DATE		24b. REGISTRAR'S SIGNATURE Arthur A. ...	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58

1950

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

CENTRAL AIRPORT

1950

REPORT OF THE DIRECTOR OF THE CENTRAL AIRPORT

FOR THE YEAR 1950

1950

REPORT OF THE DIRECTOR OF THE CENTRAL AIRPORT

FOR THE YEAR 1950

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FOR THE YEAR 1950

1950

REPORT OF THE DIRECTOR OF THE CENTRAL AIRPORT

FOR THE YEAR 1950

11397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own home				d. STREET ADDRESS Thurmont Rural			
3. NAME OF DECEASED (Type or print) First Middle Last William Elmer Clabaugh				4. DATE OF DEATH Month Day Year October 21 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1881	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchardist		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Clabaugh				14. MOTHER'S MAIDEN NAME Elizabeth Hoke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-30-5959		17. INFORMANT Address Mrs. Carrie A. Clabaugh			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the bladder 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO lying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm of the dorsal aorta							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 59 , to Oct 21 , 19 59 , that I last saw the deceased alive on Oct. 10 , 19 59 , and that death occurred at 6 p. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James K. Gray				ADDRESS (Street, city or town, state) Thurmont - Md.			
PHYSICIAN'S NAME (Type) James K. Gray				DATE SIGNED Oct 26 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-24-59		22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR Oct 26 '59	
				24b. REGISTRAR'S SIGNATURE Charles E. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11311

CERTIFICATE OF DEATH

11397

Frederick

Maryland

Frederick

Local

Thurmont

50 yrs.

Thurmont, Maryland

Own home

October 21

William Alfred Clabaugh

Oct. 17, 1881

Male

U.S.A.

Maryland

Own home

Unmarried

Elizabeth

Joseph H. Clabaugh

10-30-1959 Mrs. Carrie A. Clabaugh

12 years

Carrie A. Clabaugh

Thurmont, Maryland

Wife, also formerly

10-2-59

1959

Thurmont, Md.

Thurmont, Maryland

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11345

Reg. Dist. No.

11387

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	c. LENGTH OF STAY IN 1b Hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pt. of Rocks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore & Ohio Railroad Yards		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle WALTER Last CLEVENGER		4. DATE OF DEATH Month October Day 10 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1903
9. AGE (In years and birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Walter Clevenger	
14. MOTHER'S MAIDEN NAME Lula Hardesty		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mrs. Melva Clevenger Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DECAPITATION 800x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CRUSHED CHEST DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell Beneath Moving Railroad Car	
20c. TIME OF INJURY Month, Day, Year 4:15 Hour 10-10 19 50	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad Yard	20f. (City or town) (County) (State) Brunswick-Frederick-Maryland
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		DATE SIGNED 12 Oct 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-13-59	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Point of Rocks, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11357

CERTIFICATE OF DEATH

11346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>15 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARCELLA</u> First <u>COOK</u> Middle Last 4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1959</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 11, 1887</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John T. Hawkins</u> 14. MOTHER'S MAIDEN NAME <u>Annie Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>218-30-9899</u> 17. INFORMANT <u>Mr. J. Carlton Cook, Walkersville, Md.</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis + myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>5 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 October, 1959</u> , to <u>31 October, 1959</u> , that I last saw the deceased alive on <u>31 October, 1959</u> , and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Walkersville, Md.</u> DATE SIGNED <u>11/2/59</u> ACTUAL SIGNATURE <u>James E. Stoner Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>JAMES E. STONER JR.</u> <u>WALKERSVILLE, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.O. Barton</u> ADDRESS <u>Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Walter S. Hester</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11398

CERTIFICATE OF DEATH

Reg. Dist. No. 11347

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2		c. LENGTH OF STAY IN 1b 7 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) Near Urbana		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FORREST Middle DOFFLER Last COVELL		4. DATE OF DEATH Month October Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Sept 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Bee Keeper		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jonathan F. Covell	
14. MOTHER'S MAIDEN NAME Emma L. Doffler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Lola R. Covell (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Atrial Vascular Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-8 , 19 50 , to 10-19 , 19 59 , that I last saw the deceased alive on 10-19 , 19 59 , and that death occurred at 11:20A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 30 W. All Saints DATE SIGNED 22 Oct 1959 ACTUAL SIGNATURE U. G. Bourne Jr. M.D. Frederick, Md. PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D. Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-24-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 23 '59	24b. REGISTRAR'S SIGNATURE Carlton S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-15-1913

11-15-1913

11-15-1913

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11399 Items 2 & 17, Film G-251 10/30/59.c.

11348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 817 Homestead St.	
3. NAME OF DECEASED (Type or print) First Harry Middle Banthan Last Davis		4. DATE OF DEATH Month October Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Constuction	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Jiggs Davis	
14. MOTHER'S MAIDEN NAME Emma Hadday		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 13-08-8057		17. INFORMANT Melissa F. Miller Davis Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Thrombosis 260x DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diaebtus Melludis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 1/2 hour
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 0 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 21, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10-24-59	22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	
24a. REC'D BY REGISTRAR OCT 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH	
JAMES J. HILL		Male		45		White		1918		10:00 AM	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. DISEASE		11. INJURY		12. OTHER	
Home		Heart Disease		Natural		Coronary Artery Disease					
13. SIGNATURE OF EXAMINER		14. SIGNATURE OF DECEASED		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF NURSE	
[Signature]											
19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE		21. SIGNATURE OF CLERK		22. SIGNATURE OF RECORDS		23. SIGNATURE OF HEALTH		24. SIGNATURE OF DEATH	

10-11-18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11349

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

11400

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland Avenue			d. STREET ADDRESS Maryland Avenue		
3. NAME OF DECEASED (Type or print) First EVELYN Middle PAULINE Last DEMCHAK			4. DATE OF DEATH Month October Day 13 Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 May 1921		9. AGE (In years last birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Clark W. Boone		
14. MOTHER'S MAIDEN NAME Nellie Lare			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. Unk			17. INFORMANT Address Mr. Peter Demchak, Same as Item #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY ARTERY THROMBOSIS, ANTERIOR 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH 24 Hours
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Woodsboro,	(County) Maryland	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B. O. Thomas			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) B. O. Thomas, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Oct. 15, 1959		
22c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery			22d. LOCATION (City, town, or county) (State) Woodsboro, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE OCT 15 '59		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by law, should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11358 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G250 10-26-59 et

11350

11358

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b 40 years				d. STREET ADDRESS 510 Valley Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nannie Middle Despeaux Last Despeaux				4. DATE OF DEATH Month October Day 20 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John David Shankle				14. MOTHER'S MAIDEN NAME Christiana Buckingham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No		17. INFORMANT Mrs. Elizabeth Shade		Address Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Cystitis DUE TO Acute Cystitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paternal Sclerosis spinal cord							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 12, 1959 , to Oct 20, 1959 , that I last saw the deceased alive on Oct 20, 1959 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 West Third St DATE SIGNED 10-21-59							
ACTUAL SIGNATURE Thomas E. Stone				PHYSICIAN'S NAME (Type) Thomas E. Stone			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Bailey Jr.				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 23 '59	
				24b. REGISTRAR'S SIGNATURE Carlton L. Kline			

11359

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Fred.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick-Memorial</u>		d. STREET ADDRESS <u>460 W. Patrick St.</u>	
3. NAME OF DECEASED (Type or print) <u>Idella</u> First <u>Rebecca</u> Middle <u>Duvall</u> Last		4. DATE OF DEATH <u>10</u> Month <u>7</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 2 - 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress-Maker-Fred. Tailor Wash. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>George Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Goines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Bernard Duvall</u>		Address <u>460 W. Patrick St. Fred. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>2 years</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>Oct 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas S. Stone</u>		ADDRESS (Street, city or town, state) <u>460 3rd St Frederick 10-9-59</u>	
DATE SIGNED _____			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>	22d. LOCATION (City, town, or county) <u>Frederick - Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks</u>		ADDRESS <u>Frederick - Md.</u>	
24a. REC'D BY REGISTRAR _____		24b. REGISTRAR'S SIGNATURE _____	
DATE <u>OCT 13 59</u>		<u>C. E. Hicks</u>	

CERTIFICATE OF DEATH

11359

11359

[Faint, illegible text in a form layout, likely containing personal and medical details.]

1 ~~2~~ **M**
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11352

11401

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Middletown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Albert Last Dykes		4. DATE OF DEATH Month 10 Day 26 Year 19 59	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1915
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) section hand		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert W. Dykes		14. MOTHER'S MAIDEN NAME Daisy Henderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-5499	
17. INFORMANT Mrs. Lucille Dykes, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) DUE TO (c) Poisoning - Thionobas INTERVAL BETWEEN ONSET AND DEATH 10/24/59			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/24 , 19 59 , to 10/26 , 19 59 , that I last saw the deceased alive on 10/24 , 19 59 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 10/26/59 ACTUAL SIGNATURE J. E. Smith M.D. BRUNSWICK PHYSICIAN'S NAME (Type) J. E. Smith M.D. Brunswick			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/30/1959	
22c. NAME OF CEMETERY OR CREMATORY A.M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DATE NOV 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

REGISTRAR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by the registrar, may be retained by the hospital or attending physician.

FOR FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 8 & 9, Film G-250 10/27/59.cac

CERTIFICATE OF DEATH

11353

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Palm Beach	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 10/6/59	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 7036 Pine Tree Lane	
3. NAME OF DECEASED (Type or print) First Middle Last OTIS HENRY EATON		4. DATE OF DEATH Month Day Year October 15, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Nov 1873 1883
9. AGE (In years last birthday) 85 7/5 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tool Maker	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry W. Eaton		14. MOTHER'S MAIDEN NAME Sarah Cowan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 048-07-3365	
17. INFORMANT Mrs. Melinda Cleaver Eaton (Same as item #2)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Anterior scleritis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days 9 days 10 yrs plus	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 6 1959 to Oct 15 1959 , that I last saw the deceased alive on Oct 15 1959 , and that death occurred at 11:11A , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. R. Schoolman		DATE SIGNED 16 Oct 1959	
PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.		ADDRESS (Street, city or town, state) 228 N. Market St. Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-16-59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Lake Worth, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR Oct 19 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

11-303

CERTIFICATE OF DEATH

11380

Place of birth

Florida

Age

Sex

Place of death

Florida

Age

Sex

Place of death

Florida

Age

Sex

Place of death

Florida

Age

Sex

Place of death

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Sex

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11354

11361
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edwin Gilbert Ernst		4. DATE OF DEATH Month Oct Day 31 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Keeper		10b. KIND OF BUSINESS OR INDUSTRY Md Motor Co	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Ernst		14. MOTHER'S MAIDEN NAME Mollie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-9324	
17. INFORMANT Mrs Alice L. Ernst		Address Jefferson Fred. Co Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 10/26 , 19 59 , to 10/31 , 19 59 , that I last saw the deceased alive on 10/31 , 19 59 , and that death occurred at 7:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 10/31/59 ACTUAL SIGNATURE Henry V. Chase M.D. Fredericks Maryland PHYSICIAN'S NAME (Type) Henry V. Chase			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR NOV 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hearn	

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Film G250 10-19-59 et
 11362
 CERTIFICATE OF DEATH

11355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MOLLIE First MARIE Middle FUSS Last		4. DATE OF DEATH Oct. 11. 1959 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22. 1900
9. AGE (In years) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Frederick CO. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George Groshon		14. MOTHER'S MAIDEN NAME Mabelle Staub	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-4008	
17. INFORMANT Address Chas Walter Fuss Thurmont. R.D. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1959 to Oct 11, 1959 , that I last saw the deceased alive on Sept 19, 1959 , and that death occurred at 6:30 A.M. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Johnsville MD DATE SIGNED	
ACTUAL SIGNATURE J. H. Messler M.D.			
PHYSICIAN'S NAME (Type) J.H. Messler			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 13. 1959	22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem	22d. LOCATION (City, town, or county) (State) Thurmont. Fredk. Co. Md
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager ADDRESS Thurmont. MD		24a. REC'D BY REGISTRAR DATE OCT 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

11862

Proctor, Fredrick

Proctor, Fredrick

Proctor, Fredrick

Proctor, Fredrick

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Proctor, Fredrick

Proctor, Fredrick

Proctor, Fredrick

Proctor, Fredrick

Proctor, Fredrick

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Proctor, Fredrick

Proctor, Fredrick

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11356

11363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS 347 East Third Street			
3. NAME OF DECEASED (Type or print) First ANNIE Middle ELIZABETH Last GRASER				4. DATE OF DEATH Month October Day 15 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 15, 1884	
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months 3 Days 25 Hours 15 Min. 59		11. IF UNDER 24 HRS. Months 3 Days 25 Hours 15 Min. 59		12. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Delaughter				14. MOTHER'S MAIDEN NAME Annie Main			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-12-0879			
17. INFORMANT Mrs. William Kennedy-Sameas				Address Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis, acute 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Diabetes Mellitus DUE TO (c) 25 year						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 1955, to Oct 15 , 1959, that I last saw the deceased alive on Oct 15 , 1959, and that death occurred at 10:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert S. Turner, Jr.				ADDRESS (Street, city or town, state) East Church Street			
PHYSICIAN'S NAME (Type) Robert S. Turner, Jr., M. D.				DATE SIGNED 10/17/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19, 1959		22c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR OCT 20 '59	
24b. REGISTRAR'S SIGNATURE Crivins S. Kraus							

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BP

STATE OF NEW YORK

1933

Department of Social Welfare

Division of Child Welfare

Albany, New York

May 1, 1933

Dear Sir:

Reference is made to your letter of April 27, 1933.

The same has been forwarded to the Bureau of Child Welfare.

Very truly yours,

Director

Very truly yours,

Director

Enc.

Enc.

Enc.

Enc.

Respectfully,

Respectfully,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

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Very truly yours,

Very truly yours,

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G-253 12/11/59.cac

CERTIFICATE OF DEATH

Reg. Dist. No.

11357

11402

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAISY Middle ISABELLE Last GREEN		4. DATE OF DEATH Month October Day 28 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 April 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles McCutcheon		14. MOTHER'S MAIDEN NAME Ruth Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mr. John Green (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH not 5 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957 to Oct 28 , 19 59 that I last saw the deceased alive on Oct 24 , 19 59 , and that death occurred at 10:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 30 Oct 1959			
ACTUAL SIGNATURE W B Carpenter M.D.		PHYSICIAN'S NAME (Type) William B. Carpenter, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-2-59	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Point of Rocks, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE NOV 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

11-3-57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11364

CERTIFICATE OF DEATH

11358

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN Ib Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GLEN Middle GROVER Last GREEN				4. DATE OF DEATH Month October Day 20 Year 1959			
5. SEX Male		6. COLOR OR RACE White.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18 1904	
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.		11. BIRTHPLACE (State or foreign country) Frederick, County Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Owner				10b. KIND OF BUSINESS OR INDUSTRY Retired.			
13. FATHER'S NAME Elmer E. Green				14. MOTHER'S MAIDEN NAME Margaret Chipley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Irma Biser Green 18, W. 12 St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis Coronary vessel 1 yr. (c) Nephritis 2 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1959 to Oct 20 1959 that I last saw the deceased alive on Oct 20 1959 , and that death occurred at 5:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 E. 2nd St Frederick Md DATE SIGNED 10-21							
ACTUAL SIGNATURE Karl H. Tannenbaum M.D.				PHYSICIAN'S NAME (Type) Karl H. Tannenbaum M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF Oct. 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	
22d. LOCATION (City, town, or county) (State) Frederick, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME				ADDRESS FREDERICK, Md.		24a. REC'D BY REGISTRAR DATE OCT 23 '59	
				24b. REGISTRAR'S SIGNATURE Carlton S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

1908

1908

IN SENATE, JANUARY 13, 1908.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY: JAMES BRADY, STATE PRINTER, 1908.

THE LAND OFFICE, ALBANY, N. Y.

ALBANY, N. Y., JANUARY 13, 1908.

TO THE SENATE, AND TO THE HOUSE OF REPRESENTATIVES.

RESPECTFULLY SUBMITTED,

JOHN W. ALLEN, COMMISSIONER.

[Faint, illegible handwritten text, possibly a signature or title.]

[Extremely faint, illegible text, likely bleed-through from the reverse side of the page.]

1

11365

11359

Reg. Dist. No.

11365

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		d. STREET ADDRESS <u>1 86 Carver Apt</u>	
3. NAME OF DECEASED (Type or print) First <u>JAY</u> Middle <u>PARKER</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 Oct 59</u>
9. AGE (In years last birthday) yrs. <u>2</u> Months <u>1</u> Days <u>15</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Henry Green</u>		14. MOTHER'S MAIDEN NAME <u>Anna Mae Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO <u>Immaturity</u> <u>(birth wt 2-13)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 dys</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 Oct</u> , 19 <u>59</u> , to <u>7 Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7 October</u> , 19 <u>59</u> , and that death occurred at <u>4:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R L Guest</u>		ADDRESS (Street, city or town, state) <u>6 W 3rd St</u>	
PHYSICIAN'S NAME (Type) <u>RL GUEST</u>		DATE SIGNED <u>Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-8-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. E. Hicks</u> ADDRESS <u>Fred. Md</u>		24a. REC'D BY REGISTRAR <u>OCT 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11360

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linwood</u> 068-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>W.</u> Middle <u>Morris</u> Last <u>Haines</u>		4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/76</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph H. Haines</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH LUPTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>LULA HAINES UNION BRIDGE</u>		Address <u>RURAL MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pyclocephritis</u> DUE TO <u>610X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>prostatic hypertrophy & obstruction</u> DUE TO <u>5 yrs</u> (c) <u>Dermatitis, allergic, due to Sennadentia</u> <u>1 yr</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture neck right scapula</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off of roof</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>8 12</u> 19 <u>59</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Linwood</u> (County) (State) <u>MD</u>
21. I certify that I attended the deceased from <u>8/12/59</u> , 1959, to <u>10/29/59</u> , 1959, that I last saw the deceased alive on <u>10/29</u> , 1959, and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. P. Ygoum</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Bldg 10/29/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert H. P. Ygoum</u>		DATE SIGNED <u>Frederick, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV 1 - 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>QUAKER</u>	22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartzler & Sons Union Bridge, Md</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

CERTIFICATE OF DEATH

11226

Exp. 2001-01-01

1. NAME OF DECEASED [Handwritten: [illegible]]		2. SEX [Handwritten: Male]		3. AGE [Handwritten: 45]		4. DATE OF BIRTH [Handwritten: 1956-01-15]		5. PLACE OF BIRTH [Handwritten: [illegible]]	
6. OCCUPATION [Handwritten: [illegible]]		7. MARITAL STATUS [Handwritten: Married]		8. EDUCATION [Handwritten: High School]		9. RELIGION [Handwritten: Hindu]		10. CAUSE OF DEATH [Handwritten: [illegible]]	
11. DATE OF DEATH [Handwritten: 2001-01-01]		12. TIME OF DEATH [Handwritten: 10:00 AM]		13. PLACE OF DEATH [Handwritten: Home]		14. SIGNATURE OF DECEASED [Handwritten: [illegible]]		15. SIGNATURE OF WITNESS [Handwritten: [illegible]]	
16. SIGNATURE OF PHYSICIAN [Handwritten: [illegible]]		17. SIGNATURE OF REGISTRAR [Handwritten: [illegible]]		18. SIGNATURE OF WITNESS [Handwritten: [illegible]]		19. SIGNATURE OF WITNESS [Handwritten: [illegible]]		20. SIGNATURE OF WITNESS [Handwritten: [illegible]]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11361

11367

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 East Patrick Street				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 1001 East Patrick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle JACK Last HALLER, JR.				4. DATE OF DEATH Month October Day 15 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 19, 1914		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months 4 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry J. Haller, Sr.				14. MOTHER'S MAIDEN NAME Mary C. Haller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mr. Harry J. Haller, Jr. - Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) None DUE TO None (c) None						INTERVAL BETWEEN ONSET AND DEATH 16 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10-12, 1959 to 10-15, 1959 that I last saw the deceased alive on 10-15, 1959 and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Karl H. Tannenbaum		M.D. East Second Street		DATE SIGNED 10/17/59			
PHYSICIAN'S NAME (Type) Karl H. Tannenbaum, M. D.		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 18, 1959	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

STATE OF ALABAMA

Department of Health

Birmingham

Local Health Officer - Birmingham

City of Birmingham

February 1, 1934

Respectfully

Very truly yours,

Dr. J. H. Walker, Jr., Director

Dr. J. H. Walker, Jr.

10/1/34

Enclosed for the Birmingham Health Department are two copies of the report of the Alabama State Board of Health, dated January 1, 1934, regarding the health of the State of Alabama for the year 1933. The report contains a detailed account of the health conditions in the State, including a list of the diseases which were reported, and the number of cases of each disease. It also contains a list of the health officers in each county, and a list of the health officers in each city and town. The report is a valuable document, and it is hoped that it will be of use to the Birmingham Health Department.

Very truly yours,
J. H. Walker, Jr., Director

Enclosed for the Birmingham Health Department are two copies of the report of the Alabama State Board of Health, dated January 1, 1934, regarding the health of the State of Alabama for the year 1933. The report contains a detailed account of the health conditions in the State, including a list of the diseases which were reported, and the number of cases of each disease. It also contains a list of the health officers in each county, and a list of the health officers in each city and town. The report is a valuable document, and it is hoped that it will be of use to the Birmingham Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11362

11403

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Foxville, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Foxville, Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Alfred</u> Last <u>Hanover</u>				4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16 1915</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Ira H. Hanover</u>				14. MOTHER'S MAIDEN NAME <u>Clara Kilman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-070527</u>		17. INFORMANT <u>Ira H Hanover Lantz R D</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot wound in Chest</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>976X</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted wound</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>Oct 14 1959</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Foxville Frederick Md</u>		20f. (City or town) (County) (State) <u>Foxville Frederick Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B. O. Thomas</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. O. Thomas M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>October 28, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 30. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Foxville Fredk Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>				ADDRESS <u>Thurmont. Md</u>		24a. REC'D BY REGISTRAR <u>NOV 2 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file prior to burial, cremation, or removal. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-19-68

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for narrative notes.

• Coville Fred C. t. Oron Con ct. 3.1968

Report of death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11363

11368

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY C. HARGETT		4. DATE OF DEATH Month October Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/01.
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY City employee	
11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Luther F. Hargett		14. MOTHER'S MAIDEN NAME Emma E. Munshower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-4520	
17. INFORMANT Charles E. Hargett		Address Rt. 4. Frederick	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 19, 1959 to Oct 19, 1959 , that I lost saw the deceased alive on Oct. 19, 1959 , and that death occurred at 2:59 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE B. O. Thomas M.D.			
PHYSICIAN'S NAME (Type) B. O. Thomas Sr. MD. N. Market St. Frederick, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Oct. 22, 59	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME		ADDRESS FREDERICK, Md.	24a. REC'D BY REGISTRAR DATE OCT 23 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15382-01-10
DATE OF DEATH

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

Frederick, Frederick, Frederick

11404
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		c. LENGTH OF STAY IN 1b 60 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MOLLIE M. HARP		4. DATE OF DEATH Month Day Year October 5 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1866
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ludwig Routzahn		14. MOTHER'S MAIDEN NAME Mary Marker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jesse E. L. Harp, Myersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Advanced Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 59 , to Oct 6 19 59 , that I last saw the deceased alive on Oct 3 19 59 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. Elmer Harp M.D. Mrs. J. Elmer Harp 10-7-59			
ACTUAL SIGNATURE J. Elmer Harp		PHYSICIAN'S NAME (Type) J. Elmer Harp	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion U. B.		22d. LOCATION (City, town, or county) (State) Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle Paul F. Bittle, Myersville, Md.		24a. REC'D BY REGISTRAR Oct 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF TEXAS

1911

County of _____

State of _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11365

Reg. Dist. No.

11405 1 FilmG251 11-10-59 et

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emittsburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlston 85x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Enroute to Emittsburg				d. STREET ADDRESS I326 Grant Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Atty Middle Alix Last Lucille Harris				4. DATE OF DEATH Month October Day 28 Year 1959			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1916	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 43 Days 43 Hours 43 Min.	IF UNDER 24 HRS. Months 43 Days 43 Hours 43 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennz,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred W. Chaney				14. MOTHER'S MAIDEN NAME Ella Cain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. P18-26-1243		17. INFORMANT Mrs. Ann Pleasuer Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491x (c) 491x DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm of aortic arch							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 29, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-59		22c. NAME OF CEMETERY OR CREMATORY Harvey Kern Capital Heights, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The House Of Boyd-522-8th, S.E.				ADDRESS 522-8th, S.E.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
				24b. REGISTRAR'S SIGNATURE Clithur L. Krand			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		JAN 15 1912		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
1234 5th Ave.		Clerk		Heart Disease		Natural		None		None	
FATHER		MOTHER		SIBLINGS		MARRIAGE		PREVIOUS ILLNESS		TREATMENT	
John J. Jones		Mary J. Jones		None		1908		None		None	
BORN		DIED		AGE		SEX		RACE		DATE OF DEATH	
JAN 10 1867		JAN 15 1912		45		M		W		JAN 15 1912	
FATHER		MOTHER		SIBLINGS		MARRIAGE		PREVIOUS ILLNESS		TREATMENT	
John J. Jones		Mary J. Jones		None		1908		None		None	
BORN		DIED		AGE		SEX		RACE		DATE OF DEATH	
JAN 10 1867		JAN 15 1912		45		M		W		JAN 15 1912	

11-2-11

11-2-11

11406

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa, Md</u> 12X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>John</u> Last <u>HENNING</u>				4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/23/91</u>	
9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Adam Henning</u>		14. MOTHER'S MAIDEN NAME <u>Mary T. Zigler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-05-0568</u>		17. INFORMANT <u>Records of V.C. Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis - 002</u> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Seminoma - 178</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>70 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/23</u> 19 <u>59</u> , to <u>10/1</u> 19 <u>59</u> , that I last saw the deceased alive on <u>9/30</u> 19 <u>59</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T.F. Vesal</u>				ADDRESS (Street, city or town, state) <u>Victor Cullen State Hospital</u> <u>Cullen, Md.</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. L. Chicago & Son Therman Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. & H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11508

1. Name of deceased JAMES H. HENNING		2. Sex Male	
3. Date of birth March 15, 1895		4. Place of birth Baltimore, Md.	
5. Date of death March 15, 1950		6. Place of death Baltimore, Md.	
7. Cause of death Heart disease		8. Duration of illness Several days	
9. Name of physician Dr. J. H. H. H.		10. Name of funeral home J. H. H. H.	
11. Name of informant J. H. H. H.		12. Signature of informant J. H. H. H.	
13. Name of registrar J. H. H. H.		14. Signature of registrar J. H. H. H.	
15. Name of medical examiner J. H. H. H.		16. Signature of medical examiner J. H. H. H.	
17. Name of coroner J. H. H. H.		18. Signature of coroner J. H. H. H.	
19. Name of jury J. H. H. H.		20. Signature of jury J. H. H. H.	
21. Name of jury J. H. H. H.		22. Signature of jury J. H. H. H.	
23. Name of jury J. H. H. H.		24. Signature of jury J. H. H. H.	
25. Name of jury J. H. H. H.		26. Signature of jury J. H. H. H.	
27. Name of jury J. H. H. H.		28. Signature of jury J. H. H. H.	
29. Name of jury J. H. H. H.		30. Signature of jury J. H. H. H.	
31. Name of jury J. H. H. H.		32. Signature of jury J. H. H. H.	
33. Name of jury J. H. H. H.		34. Signature of jury J. H. H. H.	
35. Name of jury J. H. H. H.		36. Signature of jury J. H. H. H.	
37. Name of jury J. H. H. H.		38. Signature of jury J. H. H. H.	
39. Name of jury J. H. H. H.		40. Signature of jury J. H. H. H.	
41. Name of jury J. H. H. H.		42. Signature of jury J. H. H. H.	
43. Name of jury J. H. H. H.		44. Signature of jury J. H. H. H.	
45. Name of jury J. H. H. H.		46. Signature of jury J. H. H. H.	
47. Name of jury J. H. H. H.		48. Signature of jury J. H. H. H.	
49. Name of jury J. H. H. H.		50. Signature of jury J. H. H. H.	
51. Name of jury J. H. H. H.		52. Signature of jury J. H. H. H.	
53. Name of jury J. H. H. H.		54. Signature of jury J. H. H. H.	
55. Name of jury J. H. H. H.		56. Signature of jury J. H. H. H.	
57. Name of jury J. H. H. H.		58. Signature of jury J. H. H. H.	
59. Name of jury J. H. H. H.		60. Signature of jury J. H. H. H.	
61. Name of jury J. H. H. H.		62. Signature of jury J. H. H. H.	
63. Name of jury J. H. H. H.		64. Signature of jury J. H. H. H.	
65. Name of jury J. H. H. H.		66. Signature of jury J. H. H. H.	
67. Name of jury J. H. H. H.		68. Signature of jury J. H. H. H.	
69. Name of jury J. H. H. H.		70. Signature of jury J. H. H. H.	
71. Name of jury J. H. H. H.		72. Signature of jury J. H. H. H.	
73. Name of jury J. H. H. H.		74. Signature of jury J. H. H. H.	
75. Name of jury J. H. H. H.		76. Signature of jury J. H. H. H.	
77. Name of jury J. H. H. H.		78. Signature of jury J. H. H. H.	
79. Name of jury J. H. H. H.		80. Signature of jury J. H. H. H.	
81. Name of jury J. H. H. H.		82. Signature of jury J. H. H. H.	
83. Name of jury J. H. H. H.		84. Signature of jury J. H. H. H.	
85. Name of jury J. H. H. H.		86. Signature of jury J. H. H. H.	
87. Name of jury J. H. H. H.		88. Signature of jury J. H. H. H.	
89. Name of jury J. H. H. H.		90. Signature of jury J. H. H. H.	
91. Name of jury J. H. H. H.		92. Signature of jury J. H. H. H.	
93. Name of jury J. H. H. H.		94. Signature of jury J. H. H. H.	
95. Name of jury J. H. H. H.		96. Signature of jury J. H. H. H.	
97. Name of jury J. H. H. H.		98. Signature of jury J. H. H. H.	
99. Name of jury J. H. H. H.		100. Signature of jury J. H. H. H.	

11407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X UNION BRIDGE RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE MAY HOSSLER</u>				4. DATE OF DEATH Month Day Year <u>October 1 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 8 - 1872</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT SAYLER</u>				14. MOTHER'S MAIDEN NAME <u>LOU HARSHA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS BENJAMIN BLACK - UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 14</u> , 1957, to <u>Oct 1</u> , 1959, that I last saw the deceased alive on <u>Sept 30</u> , 1959, and that death occurred at <u>12:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Caricofe</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>118 S. Main St. Union Bridge MD 10/1/59</u>			
PHYSICIAN'S NAME (Type) <u>J H CARICOFE</u>				<u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 3 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D J Hartzler & Sons, New Windsor Md</u>				ADDRESS <u>118 S. Main St. Union Bridge MD</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 5 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles J. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11368

11388

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B. & O. R. R. Yards		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
3. NAME OF DECEASED (Type or print) First Samuel Middle Robert Last Hughes Sr.		4. DATE OF DEATH October 27 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26th. 1895
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard worker	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Hughes		14. MOTHER'S MAIDEN NAME Margaret Elizabeth Ditzler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-12-3554	
17. INFORMANT Mrs. Hazel Hughes		Address 307 Brunswick St. Brunswick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 910.3 Crushed Skull, DUE TO Crushed Chest (b) Multiple fractors Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.) While dismantling a freight car the bottom fell over and he was caught under steel bottom of car	
20c. TIME OF INJURY Month, Day, Year Hour a.m. XX 10/27/59 p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B&O R R Yards		20f. (City or town) Brunswick Frederick, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 28, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-30-1959	
22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		22d. LOCATION (City, town, or county) Samples Manor, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harpers Ferry, West Virginia		24a. REC'D BY REGISTRAR DATE OCT 30 '59	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1945	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		HOME	
CITY		COUNTY		STATE		FEDERAL DISTRICT		COUNTRY	
BALTIMORE		BALTIMORE		MD.		DISTRICT OF COLUMBIA		U.S.A.	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		MARRIAGE	
JAN 15 1900		BALTIMORE, MD.		HIGH SCHOOL		METHODIST		MARRIED	
FATHER'S NAME		MOTHER'S NAME		SISTER'S NAME		BROTHER'S NAME		OTHER RELATIVES	
JAMES H. HARRIS		MARY J. HARRIS		JOHN H. HARRIS		EDWARD H. HARRIS		NONE	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		SISTER'S OCCUPATION		BROTHER'S OCCUPATION		OTHER RELATIVES' OCCUPATION	
LABORER		HOUSEWIFE		LABORER		LABORER		NONE	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		SISTER'S RESIDENCE		BROTHER'S RESIDENCE		OTHER RELATIVES' RESIDENCE	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		NONE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		SISTER'S DATE OF DEATH		BROTHER'S DATE OF DEATH		OTHER RELATIVES' DATE OF DEATH	
JAN 15 1900		JAN 15 1900		JAN 15 1900		JAN 15 1900		NONE	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		SISTER'S PLACE OF DEATH		BROTHER'S PLACE OF DEATH		OTHER RELATIVES' PLACE OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		NONE	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		SISTER'S MANNER OF DEATH		BROTHER'S MANNER OF DEATH		OTHER RELATIVES' MANNER OF DEATH	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		SISTER'S PLACE OF BIRTH		BROTHER'S PLACE OF BIRTH		OTHER RELATIVES' PLACE OF BIRTH	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		NONE	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		SISTER'S DATE OF BIRTH		BROTHER'S DATE OF BIRTH		OTHER RELATIVES' DATE OF BIRTH	
JAN 15 1900		JAN 15 1900		JAN 15 1900		JAN 15 1900		NONE	
FATHER'S MANNER OF BIRTH		MOTHER'S MANNER OF BIRTH		SISTER'S MANNER OF BIRTH		BROTHER'S MANNER OF BIRTH		OTHER RELATIVES' MANNER OF BIRTH	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		SISTER'S PLACE OF DEATH		BROTHER'S PLACE OF DEATH		OTHER RELATIVES' PLACE OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		NONE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		SISTER'S DATE OF DEATH		BROTHER'S DATE OF DEATH		OTHER RELATIVES' DATE OF DEATH	
JAN 15 1900		JAN 15 1900		JAN 15 1900		JAN 15 1900		NONE	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		SISTER'S MANNER OF DEATH		BROTHER'S MANNER OF DEATH		OTHER RELATIVES' MANNER OF DEATH	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		SISTER'S PLACE OF BIRTH		BROTHER'S PLACE OF BIRTH		OTHER RELATIVES' PLACE OF BIRTH	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		NONE	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		SISTER'S DATE OF BIRTH		BROTHER'S DATE OF BIRTH		OTHER RELATIVES' DATE OF BIRTH	
JAN 15 1900		JAN 15 1900		JAN 15 1900		JAN 15 1900		NONE	
FATHER'S MANNER OF BIRTH		MOTHER'S MANNER OF BIRTH		SISTER'S MANNER OF BIRTH		BROTHER'S MANNER OF BIRTH		OTHER RELATIVES' MANNER OF BIRTH	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11369

11389

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 30 East D. Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ORRA Middle JANE Last JACOBS				4. DATE OF DEATH Month Oct Day 6 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 27, 1870	
9. AGE (In years and birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 59 Min.		11. IF UNDER 24 HRS. Months 6 Days 19 Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Michael Hunter				14. MOTHER'S MAIDEN NAME Ruth Hannah Oglan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Ollie Mundy-Same as Item #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Congestive Heart Failure DUE TO (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH 12 Hr. 2 yrs. 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY: Month Mar Day 31 Year 1958 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar. 31 , 19 58 to Oct. 6 , 19 59 , that I last saw the deceased alive on Oct. 6 , 19 59 , and that death occurred at 8:25 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 10/7/59 ACTUAL SIGNATURE C. T. Byron Kao M.D. PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 9, 1959			
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery				22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24. REC'D BY REGISTRAR DATE OCT 8 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Howard							

1130

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1130

Prothonotary

Recorder

NO. 1130

Doctor

DECEASED

NAME

RESIDENCE

LOCAL HEALTH OFFICER

DECEASED

MAN, WHITE, SINGLE, BORN IN NEW YORK

AGE

NO.

DECEASED

DECEASED

DECEASED

DATE

1130

DECEASED

DECEASED

1130

DECEASED

DECEASED

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11370

11369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				e. STREET ADDRESS 359 West Patrick Street			
3. NAME OF DECEASED (Type or print) HARRY ROGER JONES				4. DATE OF DEATH OCT 18 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 SEPT 1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drayage		10b. KIND OF BUSINESS OR INDUSTRY Drayage		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Jones				14. MOTHER'S MAIDEN NAME Virginia A. Milder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-5572		17. INFORMANT Address Mrs. Harry Brandt 359 W. Patrick St. Fred. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ch. Congestive failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart dis. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mos 5+ yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inanition due to carcinoma of tongue (10 mac)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II as item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 55 to 10/18 , 19 59 , that I last saw the deceased alive on 17 Oct , 19 59 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. Conley, Jr. M.D.				ADDRESS (Street, city or town, state) Frederick, Md DATE SIGNED 10/18/59			
PHYSICIAN'S NAME (Type) Charles H. Conley, Jr. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. [Signature]				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Knaus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11370

11371

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 6Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle ALBERT Last JONES				4. DATE OF DEATH Month October Day 6 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1871		9. AGE (In years birthday) 88 yrs.	IF UNDER 1 YEAR Months 88 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Tenant		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Jones				14. MOTHER'S MAIDEN NAME Mary McNamee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		INFORMANT 20 West 14th Street, Mr. Leroy B. Jones, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Carcinoma of the Liver 1550 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 58 , to Sept 30 , 19 59 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert S. Turner, Jr.		M.D. 2 E. Church St.		ADDRESS (Street, city or town, state) Frederick, Md.		DATE SIGNED Oct. 7, 1959	
PHYSICIAN'S NAME (Type) Robert S. Turner, Jr., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		22d. LOCATION (City, town, or county) (State) Boonsboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE OCT 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11372

11371

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 528 Lee Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CECILIA Middle MORAN Last LANDES		4. DATE OF DEATH Month October Day 12 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 27, 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 1 Days 12 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Moran		14. MOTHER'S MAIDEN NAME Mary S. Maloney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Daniel S. Landes-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Duodenal ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia & congestive heart failure 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH Hours Days-			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/12 , 19 57 , to 10/12 , 19 57 , that I last saw the deceased alive on 10/12 , 19 57 , and that death occurred at 8:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James B. Thomas		ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 10/14/59	
PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR OCT 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

11372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ROSETTA Last LAYMAN		4. DATE OF DEATH Month October Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 June 1875
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George W. Layman	
14. MOTHER'S MAIDEN NAME Sophia R. Favorite		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-34-0558		INFORMANT George M. Layman, 122 E. 6th St., Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Mellitus			INTERVAL BETWEEN ONSET AND DEATH 2 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:30 P p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 12, 1959 to Oct 30, 1959 that I last saw the deceased alive on Oct 30, 1959 , and that death occurred at 10:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. A. Pearre		ADDRESS (Street, city or town, state) 4 E. Church St. Frederick, Md.	
PHYSICIAN'S NAME (Type) A. A. Pearre, M. D.		DATE SIGNED 31 Oct 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-3-59	22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Lewistown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE NOV 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
OFFICE OF THE REGISTRAR
CERTIFICATE OF DEATH

Name of Deceased: _____ Sex: _____ Age: _____

Residence: _____ Date of Death: _____

Place of Death: _____ Cause of Death: _____

Signature of Physician: _____

Signature of Registrar: _____

Signature of Coroner: _____

Signature of Medical Examiner: _____

Signature of Burial Officer: _____

Signature of Funeral Home: _____

Signature of Cemetery: _____

Signature of Undertaker: _____

Signature of Embalmer: _____

Signature of Transporter: _____

Signature of Interment: _____

Signature of Burial: _____

Signature of Cremation: _____

Signature of Disposition: _____

Signature of Final Disposition: _____

11373
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			c. LENGTH OF STAY IN 1b <u>10 hours</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>			d. STREET ADDRESS <u>Barnesville 15x.2</u>		
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>V</u> Last <u>LILLARD</u>			4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1959</u>		
5. SEX <u>R</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 26-1892</u>	9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William E. Renn</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Smith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr J. R. Lillard, Barnesville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/30</u> , 19 <u>59</u> , to <u>10/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Richard C. Reynolds, M.D. 9 East Church St. 10/30/59</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>RICHARD C. REYNOLDS, M.D. Frederick, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>	
22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u>		24a. REC'D BY REGISTRAR <u>NOV 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Frederick, Md.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11390

Item 8 FilmG251 11-5-59 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Potomac Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eugene Middle - Last Long		4. DATE OF DEATH 10 Month 26 Day 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-15-1959 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Price Electric	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Long		14. MOTHER'S MAIDEN NAME Minnie F. Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. W. H. Long	
17. ADDRESS Brunswick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Liver Cirrhosis (c) Chronic Alcoholism	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 58 to October , 1959, that I last saw the deceased alive on October 26 , 19 59 , and that death occurred at 2 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 So. Maryland Ave. DATE SIGNED			
ACTUAL SIGNATURE C. T. Byron Kao, M.D.		PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D. Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-1959	
22c. NAME OF CEMETERY OR CREMATORY Brotherhood Heights		22d. LOCATION (City, town, or county) (State) Brownsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boys Futo		24a. REC'D BY REGISTRAR DATE NOV 2 '59	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Futo	

CERTIFICATE OF DEATH

11390

Signature of

Date

Signature of

First Name and Surname

and a common house

Age

Sex

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10-1-1939

10-1-1939

Place of Birth

Place of Birth

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11376

11408

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge R.O.I.</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge R.O.I.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		p. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Roscoe Mackley</u>		4. DATE OF DEATH Month Day Year <u>October 13 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT PLANT</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A</u>	
13. FATHER'S NAME <u>Samuel J Mackley</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Malesworth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-20-3189</u>	
17. INFORMANT <u>Mrs. Mary Edna Mackley</u>		Address <u>Union Bridge</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sun Shot wound brain</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Self-inflicted gun shot wound in brain</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted gun shot wound in brain</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>10/13 1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Union Bridge</u> <u>Frederick</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 15-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BRETHREN</u>		22d. LOCATION (City, town, or county) (State) <u>ROCKY RIDGE</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler & Sons</u>		ADDRESS <u>Union Bridge, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11377

11409

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>		c. LENGTH OF STAY in 1b <u>61 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>		d. STREET ADDRESS <u>1514 Light Street</u>	
3. NAME OF DECEASED (Type or print) <u>Fannie</u> First <u>MAE</u> Middle <u>MARRS</u> Last		4. DATE OF DEATH <u>10</u> Month <u>28</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-28-1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>10</u> Hours <u>28</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ballard Preston Marrs</u>		14. MOTHER'S MAIDEN NAME <u>Roxie Flemmings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-30-4401</u>	
17. INFORMANT <u>Record of Victor Cullen Hospital</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis - 002</u> DUE TO (b) <u>002x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>002x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive heart disease - 441</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/28</u> , 19 <u>59</u> , to <u>10/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/27</u> , 19 <u>59</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. F. Vestal</u> M.D.		ADDRESS (Street, city or town, state) <u>Cullen, Md</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Thomas F. Vestal</u>		Victor Cullen State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Swager, Son</u> ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 30 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "Jan 15, 1880"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]</p>		<p>6. OCCUPATION [Faint text, possibly "Clerk"]</p>	
<p>7. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>8. DATE OF DEATH [Faint text, possibly "Dec 10, 1915"]</p>	
<p>9. CAUSE OF DEATH [Faint text, possibly "Heart failure"]</p>		<p>10. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint signature]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11410

Reg. Dist. No. 11378

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick R.F.D.2		c. LENGTH OF STAY IN 1b Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poplar Springs		d. STREET ADDRESS 13X.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Mathias				4. DATE OF DEATH Month October Day 18 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1890	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James B. Mathias				14. MOTHER'S MAIDEN NAME Catherine Dempsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Mrs. Nellie Mathias, Mt Airy R.F.D.3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Artero Sclerosis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Minutes Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 18, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-59		22c. NAME OF CEMETERY OR CREMATORY Oak Grove		22d. LOCATION (City, town, or county) (State) Elmwood Howard Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Luther H. Haight				ADDRESS Hykesville, Md.		24a. REC'D BY REGISTRAR DATE OCT 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

— 102 —

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1000

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11374

CERTIFICATE OF DEATH

Reg. Dist. No.

11379

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN lb 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roy Middle A. B. Last Maught				4. DATE OF DEATH Month 10 Day 18 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1882	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner			10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Charles C. Maught				14. MOTHER'S MAIDEN NAME Julia K. Bowlus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT C.J. Andrew Maught, Jefferson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Uremia & Myocardial degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis & Myocarditis DUE TO 10 yrs (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 1952 to 10/18, 1959 , that I last saw the deceased alive on 10/17, 1959 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. L. Brice		M.D.		ADDRESS (Street, city or town, state) Jefferson, Md.			
PHYSICIAN'S NAME (Type) Dr. A. Talbott Brice		DATE SIGNED 10/19/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/21/1959		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Jefferson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE OCT 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	



1937

1937

[Faint, mostly illegible text and markings covering the majority of the page, possibly representing a ledger or record book.]

11411

CERTIFICATE OF DEATH

11380

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Midway</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Midway</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA LAURA MCCLAIN</u>				4. DATE OF DEATH Month Day Year <u>Oct. 30 19 59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 14, 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Francis Renner</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Harshman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mr. Jason E. Renner, New Midway, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Cor. Renal & Arterial Disease</u> DUE TO (c) <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 4 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-15</u> , 19 <u>59</u> , to <u>10-29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-29</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>U. G. Bourne Jr.</u> M.D. <u>30 Wall Street</u>							
PHYSICIAN'S NAME (Type) <u>U. G. Bourne Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rocky Ridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. C. Barton Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11511

Reg. Dist. No.

1. NAME OF DECEASED JAMES M. JONES		2. SEX Male		3. AGE 35		4. RACE White		5. PLACE OF BIRTH Maryland		6. PLACE OF DEATH Maryland	
7. DATE OF DEATH 1911		8. TIME OF DEATH 10:00 AM		9. CAUSE OF DEATH Heart Disease		10. DISEASE OR INJURY Coronary Artery Disease		11. PLACE OF INTERMENT St. John's Church		12. NAME OF MINISTER Rev. J. M. Jones	
13. NAME OF DECEASED JAMES M. JONES		14. SEX Male		15. AGE 35		16. RACE White		17. PLACE OF BIRTH Maryland		18. PLACE OF DEATH Maryland	
19. DATE OF DEATH 1911		20. TIME OF DEATH 10:00 AM		21. CAUSE OF DEATH Heart Disease		22. DISEASE OR INJURY Coronary Artery Disease		23. PLACE OF INTERMENT St. John's Church		24. NAME OF MINISTER Rev. J. M. Jones	
25. NAME OF DECEASED JAMES M. JONES		26. SEX Male		27. AGE 35		28. RACE White		29. PLACE OF BIRTH Maryland		30. PLACE OF DEATH Maryland	
31. DATE OF DEATH 1911		32. TIME OF DEATH 10:00 AM		33. CAUSE OF DEATH Heart Disease		34. DISEASE OR INJURY Coronary Artery Disease		35. PLACE OF INTERMENT St. John's Church		36. NAME OF MINISTER Rev. J. M. Jones	
37. NAME OF DECEASED JAMES M. JONES		38. SEX Male		39. AGE 35		40. RACE White		41. PLACE OF BIRTH Maryland		42. PLACE OF DEATH Maryland	
43. DATE OF DEATH 1911		44. TIME OF DEATH 10:00 AM		45. CAUSE OF DEATH Heart Disease		46. DISEASE OR INJURY Coronary Artery Disease		47. PLACE OF INTERMENT St. John's Church		48. NAME OF MINISTER Rev. J. M. Jones	
49. NAME OF DECEASED JAMES M. JONES		50. SEX Male		51. AGE 35		52. RACE White		53. PLACE OF BIRTH Maryland		54. PLACE OF DEATH Maryland	
55. DATE OF DEATH 1911		56. TIME OF DEATH 10:00 AM		57. CAUSE OF DEATH Heart Disease		58. DISEASE OR INJURY Coronary Artery Disease		59. PLACE OF INTERMENT St. John's Church		60. NAME OF MINISTER Rev. J. M. Jones	
61. NAME OF DECEASED JAMES M. JONES		62. SEX Male		63. AGE 35		64. RACE White		65. PLACE OF BIRTH Maryland		66. PLACE OF DEATH Maryland	
67. DATE OF DEATH 1911		68. TIME OF DEATH 10:00 AM		69. CAUSE OF DEATH Heart Disease		70. DISEASE OR INJURY Coronary Artery Disease		71. PLACE OF INTERMENT St. John's Church		72. NAME OF MINISTER Rev. J. M. Jones	
73. NAME OF DECEASED JAMES M. JONES		74. SEX Male		75. AGE 35		76. RACE White		77. PLACE OF BIRTH Maryland		78. PLACE OF DEATH Maryland	
79. DATE OF DEATH 1911		80. TIME OF DEATH 10:00 AM		81. CAUSE OF DEATH Heart Disease		82. DISEASE OR INJURY Coronary Artery Disease		83. PLACE OF INTERMENT St. John's Church		84. NAME OF MINISTER Rev. J. M. Jones	
85. NAME OF DECEASED JAMES M. JONES		86. SEX Male		87. AGE 35		88. RACE White		89. PLACE OF BIRTH Maryland		90. PLACE OF DEATH Maryland	
91. DATE OF DEATH 1911		92. TIME OF DEATH 10:00 AM		93. CAUSE OF DEATH Heart Disease		94. DISEASE OR INJURY Coronary Artery Disease		95. PLACE OF INTERMENT St. John's Church		96. NAME OF MINISTER Rev. J. M. Jones	
97. NAME OF DECEASED JAMES M. JONES		98. SEX Male		99. AGE 35		100. RACE White		101. PLACE OF BIRTH Maryland		102. PLACE OF DEATH Maryland	
103. DATE OF DEATH 1911		104. TIME OF DEATH 10:00 AM		105. CAUSE OF DEATH Heart Disease		106. DISEASE OR INJURY Coronary Artery Disease		107. PLACE OF INTERMENT St. John's Church		108. NAME OF MINISTER Rev. J. M. Jones	
109. NAME OF DECEASED JAMES M. JONES		110. SEX Male		111. AGE 35		112. RACE White		113. PLACE OF BIRTH Maryland		114. PLACE OF DEATH Maryland	
115. DATE OF DEATH 1911		116. TIME OF DEATH 10:00 AM		117. CAUSE OF DEATH Heart Disease		118. DISEASE OR INJURY Coronary Artery Disease		119. PLACE OF INTERMENT St. John's Church		120. NAME OF MINISTER Rev. J. M. Jones	
121. NAME OF DECEASED JAMES M. JONES		122. SEX Male		123. AGE 35		124. RACE White		125. PLACE OF BIRTH Maryland		126. PLACE OF DEATH Maryland	
127. DATE OF DEATH 1911		128. TIME OF DEATH 10:00 AM		129. CAUSE OF DEATH Heart Disease		130. DISEASE OR INJURY Coronary Artery Disease		131. PLACE OF INTERMENT St. John's Church		132. NAME OF MINISTER Rev. J. M. Jones	
133. NAME OF DECEASED JAMES M. JONES		134. SEX Male		135. AGE 35		136. RACE White		137. PLACE OF BIRTH Maryland		138. PLACE OF DEATH Maryland	
139. DATE OF DEATH 1911		140. TIME OF DEATH 10:00 AM		141. CAUSE OF DEATH Heart Disease		142. DISEASE OR INJURY Coronary Artery Disease		143. PLACE OF INTERMENT St. John's Church		144. NAME OF MINISTER Rev. J. M. Jones	
145. NAME OF DECEASED JAMES M. JONES		146. SEX Male		147. AGE 35		148. RACE White		149. PLACE OF BIRTH Maryland		150. PLACE OF DEATH Maryland	
151. DATE OF DEATH 1911		152. TIME OF DEATH 10:00 AM		153. CAUSE OF DEATH Heart Disease		154. DISEASE OR INJURY Coronary Artery Disease		155. PLACE OF INTERMENT St. John's Church		156. NAME OF MINISTER Rev. J. M. Jones	
157. NAME OF DECEASED JAMES M. JONES		158. SEX Male		159. AGE 35		160. RACE White		161. PLACE OF BIRTH Maryland		162. PLACE OF DEATH Maryland	
163. DATE OF DEATH 1911		164. TIME OF DEATH 10:00 AM		165. CAUSE OF DEATH Heart Disease		166. DISEASE OR INJURY Coronary Artery Disease		167. PLACE OF INTERMENT St. John's Church		168. NAME OF MINISTER Rev. J. M. Jones	
169. NAME OF DECEASED JAMES M. JONES		170. SEX Male		171. AGE 35		172. RACE White		173. PLACE OF BIRTH Maryland		174. PLACE OF DEATH Maryland	
175. DATE OF DEATH 1911		176. TIME OF DEATH 10:00 AM		177. CAUSE OF DEATH Heart Disease		178. DISEASE OR INJURY Coronary Artery Disease		179. PLACE OF INTERMENT St. John's Church		180. NAME OF MINISTER Rev. J. M. Jones	
181. NAME OF DECEASED JAMES M. JONES		182. SEX Male		183. AGE 35		184. RACE White		185. PLACE OF BIRTH Maryland		186. PLACE OF DEATH Maryland	
187. DATE OF DEATH 1911		188. TIME OF DEATH 10:00 AM		189. CAUSE OF DEATH Heart Disease		190. DISEASE OR INJURY Coronary Artery Disease		191. PLACE OF INTERMENT St. John's Church		192. NAME OF MINISTER Rev. J. M. Jones	
193. NAME OF DECEASED JAMES M. JONES		194. SEX Male		195. AGE 35		196. RACE White		197. PLACE OF BIRTH Maryland		198. PLACE OF DEATH Maryland	
199. DATE OF DEATH 1911		200. TIME OF DEATH 10:00 AM		201. CAUSE OF DEATH Heart Disease		202. DISEASE OR INJURY Coronary Artery Disease		203. PLACE OF INTERMENT St. John's Church		204. NAME OF MINISTER Rev. J. M. Jones	
205. NAME OF DECEASED JAMES M. JONES		206. SEX Male		207. AGE 35		208. RACE White		209. PLACE OF BIRTH Maryland		210. PLACE OF DEATH Maryland	
211. DATE OF DEATH 1911		212. TIME OF DEATH 10:00 AM		213. CAUSE OF DEATH Heart Disease		214. DISEASE OR INJURY Coronary Artery Disease		215. PLACE OF INTERMENT St. John's Church		216. NAME OF MINISTER Rev. J. M. Jones	
217. NAME OF DECEASED JAMES M. JONES		218. SEX Male		219. AGE 35		220. RACE White		221. PLACE OF BIRTH Maryland		222. PLACE OF DEATH Maryland	
223. DATE OF DEATH 1911		224. TIME OF DEATH 10:00 AM		225. CAUSE OF DEATH Heart Disease		226. DISEASE OR INJURY Coronary Artery Disease		227. PLACE OF INTERMENT St. John's Church		228. NAME OF MINISTER Rev. J. M. Jones	
229. NAME OF DECEASED JAMES M. JONES		230. SEX Male		231. AGE 35		232. RACE White		233. PLACE OF BIRTH Maryland		234. PLACE OF DEATH Maryland	
235. DATE OF DEATH 1911		236. TIME OF DEATH 10:00 AM		237. CAUSE OF DEATH Heart Disease		238. DISEASE OR INJURY Coronary Artery Disease		239. PLACE OF INTERMENT St. John's Church		240. NAME OF MINISTER Rev. J. M. Jones	
241. NAME OF DECEASED JAMES M. JONES		242. SEX Male		243. AGE 35		244. RACE White		245. PLACE OF BIRTH Maryland		246. PLACE OF DEATH Maryland	
247. DATE OF DEATH 1911		248. TIME OF DEATH 10:00 AM		249. CAUSE OF DEATH Heart Disease		250. DISEASE OR INJURY Coronary Artery Disease		251. PLACE OF INTERMENT St. John's Church		252. NAME OF MINISTER Rev. J. M. Jones	
253. NAME OF DECEASED JAMES M. JONES		254. SEX Male		255. AGE 35		256. RACE White		257. PLACE OF BIRTH Maryland		258. PLACE OF DEATH Maryland	
259. DATE OF DEATH 1911		260. TIME OF DEATH 10:00 AM		261. CAUSE OF DEATH Heart Disease		262. DISEASE OR INJURY Coronary Artery Disease		263. PLACE OF INTERMENT St. John's Church		264. NAME OF MINISTER Rev. J. M. Jones	
265. NAME OF DECEASED JAMES M. JONES		266. SEX Male		267. AGE 35		268. RACE White		269. PLACE OF BIRTH Maryland		270. PLACE OF DEATH Maryland	
271. DATE OF DEATH 1911		272. TIME OF DEATH 10:00 AM		273. CAUSE OF DEATH Heart Disease		274. DISEASE OR INJURY Coronary Artery Disease		275. PLACE OF INTERMENT St. John's Church		276. NAME OF MINISTER Rev. J. M. Jones	
277. NAME OF DECEASED JAMES M. JONES		278. SEX Male		279. AGE 35		280. RACE White		281. PLACE OF BIRTH Maryland		282. PLACE OF DEATH Maryland	
283. DATE OF DEATH 1911		284. TIME OF DEATH 10:00 AM		285. CAUSE OF DEATH Heart Disease		286. DISEASE OR INJURY Coronary Artery Disease		287. PLACE OF INTERMENT St. John's Church		288. NAME OF MINISTER Rev. J. M. Jones	
289. NAME OF DECEASED JAMES M. JONES		290. SEX Male		291. AGE 35		292. RACE White		293. PLACE OF BIRTH Maryland		294. PLACE OF DEATH Maryland	
295. DATE OF DEATH 1911		296. TIME OF DEATH 10:00 AM		297. CAUSE OF DEATH Heart Disease		298. DISEASE OR INJURY Coronary Artery Disease		299. PLACE OF INTERMENT St. John's Church		300. NAME OF MINISTER Rev. J. M. Jones	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, 18

11412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY FREDERICK CO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R#7, Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK COUNTY CHRONIC HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Noah Middle E Last Miller				4. DATE OF DEATH Month October Day 7 Year 1959			
5. SEX Male		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10. 1877	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Ringling Bros Circus		11. BIRTHPLACE (State or foreign country) Frederick, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Eli Miller				14. MOTHER'S MAIDEN NAME Mary Renner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-20-4962A			
17. INFORMANT Ruth Crawford Rn. Supt. Frederick County, Chronic Hosp.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 10 mos							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 24, 1958 , to Oct 7, 1959 , that I last saw the deceased alive on Oct 7, 1959 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. J. Keiser				ADDRESS (Street, city or town, state) DATE SIGNED 771 Market St Frederick Md Oct 1959			
PHYSICIAN'S NAME (Type) H. F. KLINE				Frederick Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10. 1959		22c. NAME OF CEMETERY OR CREMATORY Mt Tabor Cem		22d. LOCATION (City, town, or county) (State) Rocky Ridge Fredk. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, MD		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur B. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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YOUNG, J. H.

50-50-10034

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11382

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nr. Middletown		c. LENGTH OF STAY IN lb DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairplay R.F.D. I 21x-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick City Hospital			d. STREET ADDRESS Fairplay Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Eugene William Moats			4. DATE OF DEATH Month October Day 17 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1937		9. AGE (In years last birthday) 22 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer		10b. KIND OF BUSINESS OR INDUSTRY Driver Milk Truck Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hezekiah Moats			14. MOTHER'S MAIDEN NAME Lucy Hall		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-34-9539		17. INFORMANT Drivers licence Address Hezekiah M. Moats Fairplay Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture of ribs on left side DUE TO (b) with punctured wound in upper lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) left lung DUE TO (c) left lung					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 823X					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, time, place, or other details.) pinned in cab Milk truck ran thru guard rails into ditch andhe			
20c. TIME OF INJURY Month, Day, Year 9/17/59	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 A	20f. (City or town) Mile west of Middletown	(County) Frederick, Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B. O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/59		22c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	
22d. LOCATION (City, town, or county) Williamsport Wash co Md.		22e. REC'D BY REGISTRAR Oct 20 59		22f. REGISTRAR'S SIGNATURE Arthur S. Kneass	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.					

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
DEPT.

NAME OF DECEASED
KATHLEEN

RESIDENCE
BOSTON

DATE OF DEATH
MAY 11, 1933

PLACE OF DEATH
HOME

52

AGE
35

SEX
FEMALE

CAUSE OF DEATH
HEART DISEASE

DATE OF DEATH
MAY 11, 1933

U.S.A.

DECEASED'S SIGNATURE
KATHLEEN

DATE
MAY 11, 1933

DECEASED'S SIGNATURE
KATHLEEN

DATE
MAY 11, 1933

DECEASED'S SIGNATURE
KATHLEEN

DECEASED'S SIGNATURE
KATHLEEN

DATE
MAY 11, 1933

DECEASED'S SIGNATURE
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KATHLEEN

DATE
MAY 11, 1933

DECEASED'S SIGNATURE
KATHLEEN

DATE
MAY 11, 1933

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11414

CERTIFICATE OF DEATH

Reg. Dist. No.

11383

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market				c. LENGTH OF STAY IN 1b 2yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Orem				4. DATE OF DEATH Month October Day 18 Year 1959			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1897	
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) Lewisdale, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vatchel Lyles				14. MOTHER'S MAIDEN NAME Clarsia Ziegler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-30-2332		17. INFORMANT Mrs Ethel L. Dorsey, Mt. Airy, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (live clumps) metastatic 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma, sigmoid (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 months 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1959 , to Oct. 18, 1959 , that I last saw the deceased alive on Oct. 17, 1959 , and that death occurred at 2A , M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard O. Thomas Jr. M.D.				ADDRESS (Street, city or town, state) Frederick, Md.		DATE SIGNED Oct. 19, 1959	
PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/59		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Purdim, Montg. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Wolsworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE OCT 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11384

11375

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 118 West 14th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CORA Middle MAY Last PAINTER		4. DATE OF DEATH Month October Day 20 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1907
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair Shop	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George E. Ebert		14. MOTHER'S MAIDEN NAME Emma Bartgis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-03-2461	
17. INFORMANT Mr. Meredith J. Painter-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignancy of breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Specific diagnosis pending autopsy findings DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 13 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 15, 1958 to Oct 20, 1959 , that I last saw the deceased alive on Oct 17, 1959 , and that death occurred at 1:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. R. Schoolman		ADDRESS (Street, city or town, state) Professional Building	
PHYSICIAN'S NAME (Type) Louis R. Schoolman, M. D.		DATE SIGNED 10/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR OCT 23 '59	
24b. REGISTRAR'S SIGNATURE Charles L. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11376

CERTIFICATE OF DEATH

Reg. Dist. No.

11385

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b (Rural) Knoxville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS New Addition	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lacey Middle L. Last Powers		4. DATE OF DEATH Month 10 Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892 7-23-1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Carey		14. MOTHER'S MAIDEN NAME Mary Gosnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Harry O. Powers, Knoxville, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, massive 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/14 , 19 59 , to 10/16 , 19 59 that I last saw the deceased alive on 10/16 , 19 59 , and that death occurred at 9:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) 4 E. Church St	
PHYSICIAN'S NAME (Type) Henry V. Chase		DATE SIGNED 10/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-19-59	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Felt		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR DATE OCT 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

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CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Middletown	
		/d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Andrew Middle Mason Last Reinholt		4. DATE OF DEATH Month 10 Day 19 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm laborer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles R. Reinholt		14. MOTHER'S MAIDEN NAME Rebecca Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 234-24-1196	
17. INFORMANT Mrs. Andrew Reinholt		Address Middletown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of ribs on left side with 9/2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) punctute of lower left lobe of lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) farm tractor went down embankment and overturned on him	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2 p. m. 10/19 19 59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) side of road		20f. (City or town) (County) (State) Middletown, Fred, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B O Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. B. O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/23/1959	
22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Williamsburg. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR Oct 21 '59		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of death		6. Time of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of medical examiner		11. Signature of attending physician		12. Signature of coroner		13. Signature of registrar		14. Signature of clerk		15. Signature of nurse		16. Signature of other		17. Signature of other		18. Signature of other		19. Signature of other		20. Signature of other		21. Signature of other		22. Signature of other		23. Signature of other		24. Signature of other		25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other		29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other		33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other		37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other		41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other		45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other		49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other		53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other		57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other		61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other		65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other		69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other		73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other		77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other		81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other		85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other		89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other		93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other		97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	
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1. Name of deceased

2. Sex

3. Age

4. Race

5. Date of death

6. Time of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of medical examiner

11. Signature of attending physician

12. Signature of coroner

13. Signature of registrar

14. Signature of clerk

15. Signature of nurse

16. Signature of other

17. Signature of other

18. Signature of other

19. Signature of other

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11387**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 20 Wisner Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First (Also Known As) THERESA ANN RUCCI ROSSI		DATE OF DEATH Month October Day 1 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1884
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75	IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pietre Basilica		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Daniel Rossi	
17. INFORMANT Mr. Daniel Rossi		Address (same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Right Coronary Artery Thrombosis DUE TO (c) Acute Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 25 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/59	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son: Frederick, Maryland		24a. REC'D BY REGISTRAR OCT 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur J. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Items 20&21 Film 250 10-17-59 and 11416					Item 7 Film G250 10-20-59 et				
Reg. Dist. No. 11388									
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge R.F.D.			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevey Chase 15x-2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 4010 Virgilia Street				
3. NAME OF DECEASED (Type or print) First Aileen Middle Carroll Last Schwartz					4. DATE OF DEATH Month October Day 10 Year 19 59				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1920		9. AGE (In years last birthday) 39 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bruce P. Rial					14. MOTHER'S MAIDEN NAME Mary Gloninger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Harold Schwartz Rocky Ridge, R.F.D.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot wound thru heart 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accident while handling a carbine					
20c. TIME OF INJURY Month, Day, Year 4-450 P.M. 10/10/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frederick Co. Rocky Ridge R.F.D.		20f. (City or town) Frederick, Md.		(State) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .									
ACTUAL SIGNATURE B.O. Thomas M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) B.O. Thomas, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 11, 1959				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-59		22c. NAME OF CEMETERY OR CREMATORY St. Anthony Cem.			22d. LOCATION (City, town, or county) (State) near Emmitsburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager ADDRESS Thurmont, Md.					24a. REC'D BY REGISTRAR OCT 14 59		24b. REGISTRAR'S SIGNATURE Charles S. Thomas		

- 11 -

CERTIFICATE OF DEATH

Reg. Dist. No.

11378

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 5/59		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		c. STREET ADDRESS 2854 Conn. Avenue, N.W.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA		Middle LOUISE		Last SEEGER		4. DATE OF DEATH Month October		Day 16,		Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 22, 1897		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62		IF UNDER 24 HRS. Days 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Department of Commerce				10b. KIND OF BUSINESS OR INDUSTRY Board of Appeals		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Philip Seeger						14. MOTHER'S MAIDEN NAME Mary Elizabeth Brust							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		INFORMANT 327 East Patrick Street, Miss Elizabeth Seeger, Frederick, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 757.1 DUE TO Wrenia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unrecognized Polyarthritis Kidneys DUE TO Life (c) _____												INTERVAL BETWEEN ONSET AND DEATH month +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension Cardiovascular Disease													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from 10-7 , 19 59 to 10-16 , 19 59 that I last saw the deceased alive on 10-16 , 19 59 , and that death occurred at 7:30A M, from the causes and on the date stated above.													
ACTUAL SIGNATURE Thomas E. Stone				M.D. West Third Street				DATE SIGNED 10/17/59					
PHYSICIAN'S NAME (Type) T. E. Stone, M. D.				Frederick, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 19, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery				22d. LOCATION (City, town, or county) (State) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE aM. R. Etchison & Son, Frederick, Maryland						ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "CERAMIC" and "11378" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11379

CERTIFICATE OF DEATH

11390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1216, N. Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last SNYDER		4. DATE OF DEATH Month October 6, Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1900
9. AGE (In years last birthday) 59 yrs.		10. UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gulf Oil Co. employee		10b. KIND OF BUSINESS OR INDUSTRY Plant employee	11. BIRTHPLACE (State or foreign country) Frederick County Md.
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME William henry snyder	
14. MOTHER'S MAIDEN NAME Bertie Mercer Snyder		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-10-2465		17. INFORMANT Address Mrs. Alberts Lawson Snyder 1216, N. Market.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Esophagus 150X DUE TO With metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease (c) 23 yrs +			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1958 to Oct 6, 1959 , that I last saw the deceased alive on Oct 6, 1959 , and that death occurred at 1:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. O. THOMAS, MD.		ADDRESS (Street, city or town, state) DATE SIGNED 228 N. Market St Oct. 7-1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 9, 1959.	22c. NAME OF CEMETERY OR CREMATORY UNION CHAPEL, LIBERTYTOWN Maryland.
22d. LOCATION (City, town, or county) (State) Frederick, Maryland.		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DALLEY'S FUNERAL HOME FREDERICK, Maryland.	
24a. REC'D BY REGISTRAR DATE OCT 9 '59		24b. REGISTRAR'S SIGNATURE Catharine E. Harris	

11800

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

11379

Name of Deceased		Date of Death	
Name of Informant		Date of Report	
Place of Birth		Place of Death	
Sex		Age	
Marital Status		Cause of Death	
Occupation		Manner of Death	
Signature of Informant		Signature of Registrar	
Date of Signature		Date of Registration	

11380
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Howard ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Daisy 13x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hosp.				d. STREET ADDRESS RFD #2, Woodbine			
3. NAME OF DECEASED (Type or print) First Fannie Middle Elizabeth Last Stanton				4. DATE OF DEATH Month October Day 11 Year 1959			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Woodville, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Zacharias Dobson				14. MOTHER'S MAIDEN NAME Louise Dotson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Robert Stanton, Cooksville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Weeks YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/8 , 19 59 , to 10/11 , 19 59 , that I last saw the deceased alive on 10/10 , 19 59 , and that death occurred at 3³⁰ A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 EAST CHURCH ST. DATE SIGNED _____ ACTUAL SIGNATURE Richard C. Reynolds, M.D. PHYSICIAN'S NAME (Type) RICHARD C. REYNOLDS FREDERICK, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/59		22c. NAME OF CEMETERY OR CREMATORY Daisy Methodist		22d. LOCATION (City, town, or county) (State) Daisy, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter L. Woburn				24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Carbur & Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. DATE OF DEATH [REDACTED]</p>	
<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>13. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>14. DATE OF REGISTRATION [REDACTED]</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11391

CERTIFICATE OF DEATH

Reg. Dist. No.

11392

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick			
d. NAME OF HOSPITAL (If not in hospital, give street address) 305 East Potomac Street				d. STREET ADDRESS 305 East Potomac Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Wilbur Eugene Stream				4. DATE OF DEATH Month Day Year October 29 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1909	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lester S. Stream				14. MOTHER'S MAIDEN NAME Ethel Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-26-5124		17. INFORMANT Address Mrs. Lillian F. Stream (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac asthma DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 hrs 9	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/28 to 10/29 , that I last saw the deceased alive on 10/28 , and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick Md DATE SIGNED 10/29/59							
ACTUAL SIGNATURE [Signature]				PHYSICIAN'S NAME (Type) V.G.F. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-59		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Lovettville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE OCT 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11381

CERTIFICATE OF DEATH

Reg. Dist. No.

11393

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Since 5/59	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle JOSEPH Last STUP, SR.		4. DATE OF DEATH Month October Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Jan 1903
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months Days Hours Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David T. Stup		14. MOTHER'S MAIDEN NAME Hester Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-36-7127	
17. INFORMANT Mrs. Lucille M. Stup		Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/18 , 19 59 , to 10/18 , 19 59 , that I last saw the deceased alive on 10/18 , 19 59 , and that death occurred at 11:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) 4 E. Church St. Frederick, Md.	
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.		DATE SIGNED 19 Oct 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-21-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Md.	
24a. REC'D BY REGISTRAR OCT 20 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Harts	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11381

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

CAUSE

MANNER

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CERTIFICATE OF DEATH

11394

Reg. Dist. No.

11382

1. PLACE OF DEATH o. COUNTY FREDERICK, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSP		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - MYERSVILLE	
3. NAME OF DECEASED (Type or print) First NELLIE Middle KINNA Last SUMMERS		4. DATE OF DEATH Month 10 - Day 4 - Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/87
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel J. Kinna		14. MOTHER'S MAIDEN NAME Alice Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. John Gladhill, Woodsboro, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Renal Disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH years years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/2 , 19 59 , to 10/4 , 19 59 , that I last saw the deceased alive on 10/4 , 19 59 , and that death occurred at 11:45 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard C. Reynolds		ADDRESS (Street, city or town, state) 9 E. Church St.	
PHYSICIAN'S NAME (Type) RICHARD C. REYNOLDS		DATE SIGNED 10/5/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/7/1959	
22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR OCT 8 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11383

CERTIFICATE OF DEATH

11395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William E. Summers</u>		4. DATE OF DEATH Month Day Year <u>10 24 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee of Feed Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Feed Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Frederick</u>	
13. FATHER'S NAME <u>Samuel Summers</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Sarah Michael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-10-2363</u>	
17. INFORMANT <u>Alden Summers</u>		Address <u>Frederick, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>590X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Renal Insufficiency</u> DUE TO (c) <u>unknown cause Renal Infarct</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 19, 1959</u> , to <u>Oct 24, 1959</u> , that I last saw the deceased alive on <u>Oct 23</u> , 1959, and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Putnam</u> M.D.		ADDRESS (Street, city or town, state) <u>606 Lee Pl. Frederick Md</u>	
PHYSICIAN'S NAME (Type) <u>Charles Somerby Putnam Jr.</u>		DATE SIGNED <u>10/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/27/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		24. REC'D BY REGISTRAR <u>OCT 28 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

11396

11384

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Brunswick 35			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS 732 Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Beulah First M. Thompson Middle Last				4. DATE OF DEATH Month 10 Day 11 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-1895	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Michael Kidwilder				14. MOTHER'S MAIDEN NAME Mary Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Informant Mrs. Mary Cooper, Brunswick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF L. FEMORAL ARTERY 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c) DIABETES MELLITUS INTERVAL BETWEEN ONSET AND DEATH 48 HOURS YEARS YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9 EAST CHURCH ST	
20f. (City or town) (County) (State) Frederick, Mo.							
21. I certify that I attended the deceased from 10/2 , 19 59 , to 10/11 , 19 59 , that I last saw the deceased alive on 10/11 , 19 59 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 EAST CHURCH ST DATE SIGNED 10/13/59 ACTUAL SIGNATURE Richard C. Reynolds, M.D. PHYSICIAN'S NAME (Type) RICHARD C. REYNOLDS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-14-1959		22c. NAME OF CEMETERY OR CREMATORY Park Heights	
22d. LOCATION (City, town, or county) (State) Brunswick, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE B. K. Lutz				ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11397

11385

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 221 West Patrick Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis Middle Daniel Last Tomlin				4. DATE OF DEATH Month October Day 24 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 14, 1879	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mill employee				10b. KIND OF BUSINESS OR INDUSTRY Phila. Pa.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) No		16. SOCIAL SECURITY NO. 214-10-5646		17. INFORMANT Address Mrs. Phoebe Mae Tomlin Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 hours
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 25, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. [Signature]				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR OCT 27 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

11417

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora J. Toms</u>				4. DATE OF DEATH Month Day Year <u>10 14 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/1892</u>		9. AGE (In years lost birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Holmes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address <u>Herman S. Toms, Myersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-24</u> , 19 <u>59</u> , to <u>10-14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-12</u> , 19 <u>59</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Charles F. Hess</u> M.D. <u>Smithsburg, Md.</u> <u>10-15-59</u>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) <u>Charles F. Hess M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/17/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

LINE 1

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11418 CERTIFICATE OF DEATH

11399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foxville		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz P.O.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Toms				4. DATE OF DEATH Month October Day 2 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Simon P. Kuhn				14. MOTHER'S MAIDEN NAME Amelia Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. no		INFORMANT Address Ulysses S. Toms Lantz, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Vulva 176.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET OF DEATH 6 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 15, 1959 to Sept. 25, 1959 that I last saw the deceased alive on Sept. 25, 1959 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James K. Gray		M.D. 502 E. Main		ADDRESS (Street, city or town, state) Thurmont - Md. DATE SIGNED 10/2/59			
PHYSICIAN'S NAME (Type) James K. Gray							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-4-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Garfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE OCT 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur G. Hume			

CERTIFICATE OF DEATH

Frederick

Frederick

Forville

30 yrs.

Jan 20

October 2

1880

Virginia

White

Female

White

X

Dec. 2, 1880

78

Howardsville

Own home

Maryland

U.S.A.

Simon P. Rahn

Amelia Harrison

No

Divided 2. Total

1000

100

James H. Gray

Burial

10-1-80

St. Peter's Cemetery

Carlisle, Maryland

David H. Green

Thurmont, Md.

11419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodstock, Rural</i>		c. LENGTH OF STAY in 1b <i>4 yrs.</i>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Woodstock</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>IDA</i> Middle <i>MAE</i> Last <i>VANFOSSEX</i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>23</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 19, 1885</i>		9. AGE (In years last birthday) <i>74</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John A. Biddinger</i>				14. MOTHER'S MAIDEN NAME <i>Ida Edres</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Mr. Allan W. Van Essex, Woodstock, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) <i>10 years</i>							INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary fibrosis & emphysema</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October, 1954</i> to <i>10/23, 1959</i> , that I last saw the deceased alive on <i>10/22, 1959</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James E. Stoner Jr.</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>Walkersville, Md 10/24/59</i>			
PHYSICIAN'S NAME (Type) <i>JAMES E. STONER, JR.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 25, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Chapel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Libertytown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Barton</i>				ADDRESS <i>Walkersville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 27 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11386

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Since-4/39			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Odd Fellows Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle EDITH Last WACHTER				4. DATE OF DEATH Month October Day 13 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Sept 1866	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob E. Palmer				14. MOTHER'S MAIDEN NAME Matilda C. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Maryland Odd Fellows Home Address (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 Hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 49 to Oct. 13, 19 59 , that I last saw the deceased alive on Oct. 13, 19 59 , and that death occurred at 3:35 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wm M. Smith</i>		M.D. 4 E. Church St.		DATE SIGNED 15 Oct 1959			
PHYSICIAN'S NAME (Type) William M. Smith, M. D.		Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR OCT 19 59	
				24b. REGISTRAR'S SIGNATURE <i>Robert S. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 1. A schematic diagram of the experimental setup. The subject is seated in a chair, viewing a video screen. The screen displays a target (a small circle) and a starting point (a larger circle). The subject's hand is positioned at the starting point. The distance between the starting point and the target is labeled as 'Distance'. The subject is instructed to move their hand from the starting point to the target. The video screen is connected to a computer system, which records the hand's position and movement time.

CERTIFICATE OF DEATH

11402

Reg. Dist. No.

11420

1. PLACE OF DEATH a. COUNTY— <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY— <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADDOCK HTS.</u>				c. LENGTH OF STAY IN 1b <u>60 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRADDOCK HTS. MD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>D.</u> Middle <u>G.</u> Last <u>White</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE-7-1860</u>	
9. AGE (In years last birthday) <u>99</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>THOROUGH BRED HORSES</u>			
11. BIRTHPLACE (State or foreign country) <u>GRAND VALLEY PA. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>AMOS WHITE</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET FENTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. JEAN W. BAST BRADDOCK HTS. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>53</u> , to <u>Oct 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>59</u> , and that death occurred at <u>12:51</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Stone</u> M.D.				ADDRESS (Street, city or town, state) <u>4 West Thurst</u>			
DATE SIGNED <u>10-27-59</u>							
PHYSICIAN'S NAME (Type) <u>Thomas E. Stone</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		22b. DATE THEREOF <u>Oct 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO MAUSOLEUM</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carroll L. Stewart</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11421

CERTIFICATE OF DEATH

Reg. Dist. No.

11403

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle P. Last Wiles				4. DATE OF DEATH Month 10 Day 18 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/1863		9. AGE (In years lost birthday) yrs. 96	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner, ret.		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Wiles				14. MOTHER'S MAIDEN NAME Barbara Shibbitti			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT George E. Wiles, Middletown, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 16 , 19 59 , to Oct 18 , 19 59 , that I last saw the deceased alive on Oct 16 , 19 59 , and that death occurred at 8 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middletown DATE SIGNED 10-19-59							
ACTUAL SIGNATURE J. Elmer Harp M.D.				PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/20/1959		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE OCT 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

ORIGINAL FILED

Wash D.C.

11521

CERTIFICATE OF DELIVERY

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF HEALTH

11403

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11404

11422 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Fred			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK Braddock Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK,			
c. LENGTH OF STAY IN 1b LIFETIME							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VINDOBONA NURSING HOME.				d. STREET ADDRESS BRADDOCK HEIGHTS MARYLAND.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) DAISY MARIAN ISABELLE WINKLE				4. DATE OF DEATH October 28 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY homemaker		11. BIRTHPLACE (State or foreign country) Frederick md.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Jacob Franklin Thomas Grove				14. MOTHER'S MAIDEN NAME Clara Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Cleveland T. Grove		Address 479, W. Patrick St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition DUE TO (c) Rheumatoid arthritis						INTERVAL BETWEEN ONSET AND DEATH 10 day undetermined 6 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyper Tonic						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 22, 1959 , to Oct 28, 1959 , that I last saw the deceased alive on Oct 28, 1959 , and that death occurred at 3:45 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. Lawrence Fahrney M.D.				ADDRESS (Street, city or town, state) 17 E. Second St. Frederick			
PHYSICIAN'S NAME (Type) H. LAWRENCE FAHRNEY MD.				DATE SIGNED 10-28-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/31/59		22c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) FREDERICK, MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME				ADDRESS FREDERICK, MARYLAND.		24a. REC'D BY REGISTRAR NOV 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Knapp							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11495

11423

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillie Middle Blanche Last Yingling		4. DATE OF DEATH Month Oct. Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1884
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Cover	
14. MOTHER'S MAIDEN NAME Ann Mikesell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. H. Yingling Address Thurmont, Md. RD 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic hypertensive cardiovascular disease DUE TO (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 8 weeks several years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1957 , to Oct. 30 , 19 59 , that I last saw the deceased alive on Oct. 30 , 19 59 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest A. Dettbarn		ADDRESS (Street, city or town, state) DATE SIGNED Walthamville, Md. Oct. 30/59	
PHYSICIAN'S NAME (Type) ERNEST A. DETTBARN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-2-59	22c. NAME OF CEMETERY OR CREMATORY United Brethren Cem.	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

CERTIFICATE OF DEATH

11-2-59		11-2-59	
The undersigned, a duly qualified physician, do hereby certify that the above named person died on the 2nd day of November, 1959, at the residence of the deceased, 11-2-59, Baltimore, Maryland.		The undersigned, a duly qualified physician, do hereby certify that the above named person died on the 2nd day of November, 1959, at the residence of the deceased, 11-2-59, Baltimore, Maryland.	
Name of deceased: David Cover		Name of deceased: David Cover	
Sex: Male		Sex: Male	
Age: 75		Age: 75	
Race: White		Race: White	
Marital status: Married		Marital status: Married	
Usual residence: Baltimore, Maryland		Usual residence: Baltimore, Maryland	
Place of death: Baltimore, Maryland		Place of death: Baltimore, Maryland	
Cause of death: (to be filled in by physician)		Cause of death: (to be filled in by physician)	
Immediate cause of death: (to be filled in by physician)		Immediate cause of death: (to be filled in by physician)	
Underlying cause of death: (to be filled in by physician)		Underlying cause of death: (to be filled in by physician)	
Contributing causes: (to be filled in by physician)		Contributing causes: (to be filled in by physician)	
Manner of death: (to be filled in by physician)		Manner of death: (to be filled in by physician)	
Signature of physician: (to be filled in by physician)		Signature of physician: (to be filled in by physician)	
Date: 11-2-59		Date: 11-2-59	